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## TRACT

Two forms of continuing education (CE) in nursing  
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in both studies was composed of twenty-two items dealing with  
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field/place of employment were significantly related to  
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ger: better educated; employed full-time in nursing in a  
ital, school of nursing, or public health agency; and practicing  
n acute care situation and a relatively high status position.

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CONTINUING EDUCATION IN NURSING: A STATUS REPORT

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The title of my paper is "Continuing Education in Nursing: A Status Report." The status of continuing education in nursing can be best described as "living and well in primarily two forms." The two forms in which continuing education in nursing exists are those forms which are common to continuing education for all professionals - voluntary continuing education and continuing education which is mandatory, for continued employment, for membership in an organization, or to maintain licensure to practice in the profession. I will first describe the voluntary form briefly then turn to mandatory continuing education in the nation and then share one state's approach to mandatory continuing education including a description of the studies which provided an empirical basis for the decision to implement mandatory continuing education.

Voluntary continuing education is the form most common in the United States and also overseas. There are not accurate figures available about the number of nurses overseas, but estimates suggest that more than 20,000 American nurses serve in areas outside the continental U.S. Most of those are missionary nurses, but nurses also work for governmental agencies, the Peace Corps, WHO, CARE, and the Armed Forces. In 1975 an organization named OCEAN (Organization of Continuing Education for American Nurses), was formed to provide continuing education opportunities for nurses overseas. The organization is funded by contributions; volunteers teach workshops in their area of expertise in Asia, Africa and Latin America. Workshops are also available in various locations in the states for nurses on furlough.

Varying degrees of "mandating" continuing education (CE) exist in

the United States. In some instances employers of nurses require participation in CE for continued employment; for example, a nursing home in southern Indiana requires each registered and licensed practical nurse employed there to participate in 10 hours of CE per year. Some employers require participation in CE as one of the criteria for promotion eligibility, while others utilize CE participation in the performance appraisal process or in determination of eligibility for merit raises. CE participation is required for membership in the American Academy of Occupational Health Nursing and for re-certification of critical care nurses. In some states, 11 to be exact, CE participation is a requirement for licensure renewal.

The pattern for CE participation to be legislated as a re-licensure requirement has slowed somewhat in the recent years. About 10 years ago, one would have predicted that a majority of states would have legislated CE requirements for professional nurses, but that is not the case today. A review of the status of the CE requirements in the various states will shed some light on the slowed momentum.

California was the first state to initiate CE requirements for its nursing practitioners. The date when evidence of CE was required for registered nurses was July 1, 1978; the requirement was for 30 clock hours of participation every two years. That requirement breaks down to 15 hours per year, or a little over 1 hour per month. California's implementation of mandatory continuing education (MCE) has been fraught with difficulty. The Board of Nursing approved a number of providers of CE; that number has exceeded 1500. Many commercial firms responded

almost overnight to the need being expressed by nurses to "collect the required number of hours;" they provided CE which offered the necessary hour accumulation but in many instances added little of value to the nurse's practice. The California Consumer Affairs Administration opposes MCE on the basis that there is no definitive evidence that CE improves nursing practice. Recently Consumer Affairs officials have pointed to educational offerings on topics such as political strategy, union busting and financial planning as evidence of their claim. The Board of Nursing is in the process of determining the feasibility of moving toward individual educational offering approval, rather than blanket approval of providers. Such a move would greatly increase the workload of the Board, but might be effective in curbing the abuses to which the Consumer Affairs Administration is responding.

The MCE requirement for Colorado nurses was rescinded by the legislature early in 1980. Again, there had been difficulties in the implementation of the requirement, some related to the timeliness with which the rules and regulations surrounding the requirement were promulgated. The Board of Nursing in Colorado has the authority to formulate and adopt rules and regulations making CE mandatory once again. It is thought that the Board will reinstate MCE.

In Florida under the sunset review process, the Board of Nursing reduced the continuing education requirement from 30 to 24 hours per two years. The Board recently disclosed that twenty months into the MCE program, with only four months to go before licensure renewal of December 31, 1980 for the 110,000 actively licensed nurses in Florida, 22%

had NO contact hours earned (some of that number may have earned contact hours, but not yet reported them to the Board), 30% have more than the required 24 hours, and the remaining 48% have between 1 and 23 hours. It is not certain how many of these actively licensed nurses are actually practicing nursing in Florida since many nurses retain active licenses in several states. In contrast, only a few hundred of Iowa's 35,000 nurses have failed to accrue their 15 hours per year. Perhaps the \$50.00 "delinquent penalty" was an inducement to meet the requirement!

In Kansas, there was an incremental requirement; in the first biennium following the institution of MCE, 5 hours were required; in the second biennium 15 hours were required and subsequently 30 hours will be required every two years. Kentucky has a similar requirement, but the increment is 5, 10 and 15. Massachusetts has requirements on an incremental basis which are the same as Kentucky's.

Minnesota's initial requirement was for 15 hours; nurses who were unable to obtain the full 15 hours were permitted to add the missing hours to the next renewal period, however, that option was only available for the initial renewal period under the system. At the next renewal period, in 1982, the requirement will be for 30 hours.

The requirement for CE in Nebraska is somewhat different from that of other states; 20 clock hours of participation plus 200 clock hours of practice are required every 5 years; if the nurse does not practice clinically, then the requirement is for 75 clock hours of participation in CE activities.

In Nevada the requirement is for 30 hours every two years, beginning

in 1982. A group of nurses, reportedly funded by the Hospital Association in that state has begun efforts to repeal MCE during the 1981 legislative session.

In South Dakota the MCE legislation was repealed largely through the combined efforts of the Hospital Association, the Medical Association and the Nursing Home Association in that state.

New Mexico has an incremental requirement for 20 hours the first renewal period, effective January 1981, and 30 hours every two years afterwards. Washington state has not yet implemented their CE requirement because funds have not yet been appropriated for that purpose.

Several states have continuing education requirements only for certain categories of nurses, such as clinical specialists, or nurse practitioners.

In Indiana, as early as 1970, concerns about the imminence of MCE were expressed by nurses across the state. Many of us in continuing education were actively involved in dispelling fears about MCE; a position statement on Indiana's pro-voluntary stance was printed and widely distributed. The pros and cons of MCE were debated frequently by continuing educators. A Work Group formed by the Indiana State Nurses' Association's (ISNA) Committee on Legislation began work on a Model Piece of Legislation in the interest of "being prepared." Presentations to nurses across the state included information about the Work Group's progress with emphasis on the reasonableness of the requirements being proposed in the model legislation. Regional hearings conducted to obtain nurses' input about the proposed legislation were only mildly successful. Attendance was not as expected, perhaps because fears had been quieted.

One popular notion expressed by many nurses in Indiana was that MCE would not become a reality if "nurses would attend continuing education activities on their own." Although most nurses knew that Indiana would not act precipitously in implementing a continuing education requirement for relicensure, many of those same nurses felt that MCE was avoidable. It seemed appropriate to determine whether nurses were indeed attending continuing education activities on a voluntary basis.

If part of the rationale for MCE in Indiana was to be the lack of nurses' participation on a voluntary basis, CE attendance had to be studied. In 1975 a study was conducted which revealed an average attendance rate of 69% and an average rate of nonattendance of 31%. Significant differences in attendance were based on the nurse's age, marital status, basic educational preparation, employment position, area of clinical practice, place of employment and length of employment.

No action on MCE was taken at that time. In 1978 when MCE again became an issue with the passage of legislation requiring CE for relicensure of Pharmacists, Optometrists and Podiatrists, a replication of the 1975 study was conducted to determine whether CE attendance of nurses had changed over the past three years.

The purpose of the 1978 study was to provide data for comparison of attendance patterns of registered nurses in 1975 and in 1978. The study results would also provide a data base upon which a decision about MCE for nurses could be based.

Hypotheses to be tested were stated in null form.

1. There is no significant difference in participation in continuing

education activities by registered nurses based upon the characteristics of:

- a) age
- b) marital status
- c) basic educational preparation in nursing
- d) level of highest education completed
- e) employment status
- f) place of employment
- g) employment position
- h) clinical area of nursing practice, or
- i) length of employment (continuous or interrupted).

2. There is no significant difference in participation in continuing education activities by registered nurses in Indiana since 1975.

#### METHOD

##### The Instrument

The same instrument used in the 1975 study was used in the 1978 study. The instrument was a questionnaire composed of 22 items, among which 12 were designed to elicit demographic information about the respondents, one was concerned with employment history, five dealt with participation or non-participation in continuing education activities, and four elicited reasons which influenced attendance or non-attendance. The questionnaire was pilot tested twice on groups of registered nurses in local hospitals; changes were made in the instrument based on the comments and suggestions from these two groups of nurses. The questionnaire was tested for reliability using a test-retest method. A measure of agreement between responses was used for all items, since some of the questionnaire items

did not lend themselves to calculation of correlation coefficients. The percentage of agreement for the majority of the questionnaire items was uniformly high. The low percentage of agreement (62-69%) on the items dealing with employment and continuing education histories was most likely due to the difficulty of those items. The questionnaire was assumed to have content validity.

#### The Subjects

A ten percent random sample of the 31,816 registered nurses licensed and residing in the state of Indiana was selected by computer from the listing of the Indiana State Board of Nurses' Registration and Nursing Education (ISBNR&NE). Sample selection in this manner helped assure that the sample was representative of the general population of registered nurses in the state of Indiana.

#### Procedures

The questionnaire was mailed with a cover letter explaining that the nurse's name had been chosen at random from the ISBNR&NE list and that the study was being conducted to obtain "useful information on the continuing education habits of registered nurses." The respondent was informed that the questionnaire would take about 15 to 20 minutes to complete, based on the average time for completion required by respondents in the two pilot tests. The questionnaire was accompanied by a self-addressed stamped envelope. The respondent was advised that the survey was anonymous, that the questionnaire should be returned promptly, and that there would be no follow-up of non-returned forms.

A total of 3,137 questionnaires were mailed. Of these, 84 were returned

by the post office as undeliverable. A total of 1,435 questionnaires were returned, a return rate of 47 percent. Of these, 1,407 were complete and were analyzed by the computer. Initially, the data were key-punched onto computer cards, and a computer read-out of that data requested. A random check of one percent of the original questionnaires with the computer print-out revealed that the data had been key-punched with accuracy.

Initial data analysis was a simple frequency count. Subsequent data analysis involved Chi Square as a specific statistic. The level of significance was established at  $p$  equals .05.

#### DATA ANALYSIS

Preliminary analysis of the data obtained revealed that of the 1,407 registered nurses who responded to the questionnaire, 98 percent were female, and 2 percent were male. The median year of birth was 1941. Of the respondents, 15 percent were single, 76 percent were married, and 9 percent were either widowed, divorced or separated. The median number of dependents was one. The basic educational preparation in nursing for 62 percent of the respondents was a diploma in nursing; 20 percent of the respondents were graduates from an associate degree program, and 18 percent were baccalaureate graduates. The median year of graduation from the basic educational preparation in nursing was 1962.

Respondents were asked to indicate their highest level of education completed. The highest level for 54.5 percent of the respondents was a diploma in nursing, while 17 percent indicated they had obtained an associate degree in nursing. Respondents who had a baccalaureate in nursing

totalled 19 percent; those with a baccalaureate in fields other than nursing comprised 4 percent. Respondents with master's degrees in nursing were 3 percent, while 1.5 percent indicated they had completed master's degrees in other fields. There were no respondents with doctoral degrees in nursing and only 3 respondents (0.2%) reported having doctorates in fields other than nursing. The non-response rate for this item was less than 1 percent. The median year for graduation from the highest level of education completed was 1963.

Most of the respondents (55%) were currently employed full-time in nursing. Those respondents employed part-time in nursing numbered 25 percent. Three percent of the respondents were employed in a field other than nursing either on a full-time or a part-time basis. Of the respondents who reported their status as unemployed, 1 percent were looking for work, 11 percent were not looking for work, 2 percent were retired, 1.5 percent classified themselves as students, and 1 percent indicated some unemployment status under the category of "other."

Most of the respondents (48%) were general duty or staff nurses; 11 percent reported that they were head nurses or assistants; 6 percent were in administrative or assistant administrative positions; 1 percent were clinical specialists; 3 percent were instructors; 7 percent were supervisors or assistant supervisors; 2 percent were teachers in schools of nursing and less than 1 percent indicated that they were consultants. Five percent indicated their position fell into the category of "other." Positions which were classified in this category included utilization review coordinator, nursing audit coordinator, nurse anesthetist, camp nurse,

researcher, and others. The non-response rate for this question was 16 percent.

When asked for current place/field of employment, 49 percent indicated they worked in a hospital, while 3 percent were employed in industry, 8 percent in nursing homes, 9 percent were nurses in physicians' or dentists' offices, 1 percent were engaged in private duty nursing, 2.5 percent were employed in public health nursing, excluding school nursing, in which 3 percent were engaged. Three percent were employed in schools of nursing, and 6 percent indicated their place of employment fell under the category of "other." Most of the respondents who marked the category of other were employed in clinic settings, such as family planning, drug or alcohol abuse clinics. Several respondents were employed by the American Red Cross in blood banks and several more were in some branch of the Armed Services. The non-response rate for this question was 15 percent.

When asked about their current major clinical teaching or practice area, 20 percent indicated medical/surgical nursing, 8 percent were involved in geriatric nursing, 7.5 percent were in either Intensive or Coronary Care Units, 7 percent were in community health, 7 percent were in pediatric/maternal health, 6 percent were in gynecological/obstetrical nursing, 3 percent were in psychiatric/mental health nursing, and 1.5 percent were in in-service/staff development. Nineteen percent of the respondents indicated their clinical area of practice fell into the category of "other." These respondents were most often working in areas such as operating rooms, recovery rooms, and emergency departments. The non-response rate for this item was 20.5 percent.

Respondents were asked to respond to an item concerned with attendance at continuing education activities. The definition of continuing education used in the determination of attendance or non-attendance was "Continuing education in nursing consists of planned learning experiences (conferences, seminars, workshops, etc.) beyond the basic nursing education program. These experiences are distinct from education toward an academic degree and are designed to promote the development of knowledge, skills, attitudes for the enhancement of nursing practice."<sup>1</sup> Attenders were those respondents who indicated that they had attended continuing education activities in the previous five years. Seventy-six percent of the respondents (1,065) indicated that they had attended some continuing education activities. Non-attenders were those respondents who reported that they had not attended continuing education activities in the past five years. Twenty-four percent of the respondents, or 340, indicated that they had not attended any continuing education activities in the previous five years. Two respondents did not respond to this item on the questionnaire.

#### Patterns of Attendance

Following the initial data analysis, the respondents' questionnaires were divided into two groups: attenders and non-attenders.

Attendance was compared with age. Attenders tended to be slightly younger than non-attenders, but this difference was not statistically significant.

Attendance was compared with marital status. Single nurses attended continuing education activities at a rate only slightly above the average rate of attendance (76 percent). Married nurses attended at a rate only

slightly below average. Nurses who classified their marital status as widowed, divorced, or separated attended at a rate slightly above average. Marital status was not found to be related to continuing education attendance at a statistically significant level.

Attendance was compared with basic educational preparation in nursing. Diploma nurses were slightly over-represented in the category of non-attenders. Associate degree and baccalaureate graduates were somewhat more likely to be attenders than non-attenders. Differences in attendance based on basic educational preparation were not statistically significant.

Attendance was compared with the highest level of education completed by the respondent. Diploma nurses were attenders at a rate below the average rate of 76 percent. Nurses with associate degrees or baccalaureates in nursing attended at a rate slightly above average. Nurses with baccalaureates in fields other than nursing attended continuing education at a rate above average, as did nurses with master's degrees in nursing. Nurses with master's degrees in areas other than nursing reported attending at a rate much higher than average, and that rate was higher than the rate of any of the other groups. The difference in rates of attendance based on the highest level of education completed reached statistical significance.

Attendance was compared with employment status. Nurses employed full-time in nursing attended continuing education activities at an above average rate. Nurses employed part-time in nursing attended at a rate slightly above average. Nurses employed full-time in fields other than nursing attended at a below average rate, but the rate of attendance was not as far below average as that for nurses employed part-time in fields

other than nursing. Nurses who were unemployed and looking for work attended at a rate below average, but again not as far below the average as the rate for nurses who were unemployed but not looking for work. The attendance of retired nurses was far below the average. The attendance of students was also far below average. Nurses who classified their unemployment status as "other" attended at a below average rate. The difference in rates of attendance based on employment status was statistically significant.

Attendance was compared with the respondents' current field/place of employment. The average rate of attendance for this variable was 81 percent, since a large number (209) of the respondents did not answer this question. Nurses employed in hospitals attended continuing education activities at above average rates, as did nurses in industry. Nurses employed in public health or in schools of nursing were attending at above average rates. Nurses in private duty were attending at slightly above average rates. Nurses employed in school systems were attending at a near average rate. Nurses employed in nursing homes were attending at a below average rate. Nurses employed in physicians' offices and those whose field of employment was classified as "other" attended continuing education at rates which were far below average. The difference in rates of attendance based upon the current field/place of employment of the respondent was statistically significant.

The respondents' type of position was compared with attendance. Compared to the average rate of attendance (76 percent), administrators or assistants attended at a rate far above the average. Clinical specialists

reported an attendance rate of 100 percent; however, only 14 respondents were clinical specialists. Consultant nurses had an attendance rate slightly below average. Staff nurses attended at a below average rate. Head nurses attended at a rate slightly above average. Instructors, teachers in schools of nursing and supervisors were attenders at an above average rate. Nurses who indicated that their position fell into the category of "other" attended at a below average rate. The difference in rate of attendance based on type of position was statistically significant.

Area of clinical practice was compared with attendance. Again a large number (289) of respondents did not answer this question, so that the average rate of attendance for this variable was 82 percent. Community health nurses and nurses in pediatric/maternal health attended at a rate only slightly above average. Nurses in gynecological/obstetrical and intensive/coronary care had above average attendance rates. Nurses in in-service/staff development had the highest above the average rate of attendance. Nurses in geriatrics, medical/surgical nursing, psychiatric/mental health nursing, and those classified as "other" had attendance rates below the average. None of the differences in attendance based on clinical area of practice approached statistical significance.

Attendance was compared with years since graduation from basic preparation in nursing, years of full-time employment in nursing, years of part-time employment in nursing, and years not employed in nursing at all. Attenders had more recently graduated from their basic educational preparation in nursing and had longer periods of full-time employment in nursing. However, these trends did not reach statistical significance.

The relationship between unemployment and non-attendance was statistically significant. The longer the period of unemployment, the more likely the tendency toward non-attendance.

#### Comparison of 1975 and 1978 Studies

A statistical analysis of the demographic characteristics of the respondents in 1975 and in 1978 indicated that there were no significant differences between the two samples in regard to the number of dependents, clinical area of practice, employment status, position, place of employment, or nursing employment history. A significant difference occurred between the groups when comparing age and marital status. These differences could be attributed to the fact that a larger proportion of single nurses responded in 1978 than in 1975. Conversely, proportionately fewer married nurses responded in 1978 than did in 1975.

A significant difference was also noted in the basic educational preparation of the respondents in the two studies. Proportionately fewer diploma nurses responded in 1978, while the proportion of baccalaureate and associate degree graduates responding increased markedly. Comparison of highest level of education completed also resulted in a significant difference between the respondents in the two studies because fewer diploma nurses and more associate degree and baccalaureate graduates responded. The respondents with master's degrees did not change appreciably between the two studies. In summary, the two samples resembled each other rather closely on six out of the ten demographic variables. The only exception occurred with the second sample in that single and somewhat better educated nurses were slightly over-represented as respondents.

The factor of participation in continuing education activities (attendance or non-attendance) was compared for the respondents in 1975 with the respondents in 1978. In 1975 the average rate of attendance was 69 percent and the average rate of non-attendance was 31 percent. In 1978 the average rate of attendance had increased to 76 percent, while the average rate of non-attendance had decreased to 24 percent. The proportion of nurses who were attenders increased substantially from 1975 to 1978. Conversely, the proportion of those nurses not attending continuing education activities decreased substantially between 1975 and 1978. The difference in the rate of attendance between the two groups (1975 and 1978) reached a high degree of statistical significance.

In the 1978 study four of the nine personal/professional characteristics studied did significantly influence attendance. Employment status, highest level of education completed, position, and field/place of employment were significantly related to attendance. Variables such as age, marital status, basic educational preparation in nursing, clinical area of nursing practice, and the number of years since graduation from the basic educational preparation or the length of employment (either full-time or part-time) were not significantly related to attendance.

The tendency for better educated nurses to attend continuing education activities was apparent but not statistically significant. Similarly, nurses employed full-time in nursing were attending continuing education at a much higher rate than any other group of nurses. Apparently, the more nurses work and the more the work is related to nursing, the more they attend continuing education activities. Nurses employed in hospitals

are more likely to be attenders than nurses employed in single-nurse situations such as industry, schools, or physicians' offices. Nurses at relatively low levels in the profession, such as general duty or staff, were less inclined to attend continuing education activities. The higher a nurse was on the professional hierarchy, the more likely he/she was to attend continuing education activities. Nurses working in acute care displayed a tendency to be continuing education attenders more than did their colleagues working in more chronic or long-term care areas of clinical practice.

Continuing education attendance increased significantly since 1975. The hypothesis that there was no significant difference in participation in continuing education activities by registered nurses since 1975 was, therefore, rejected.

The continuing education attenders in 1978 were still more likely to be younger, better educated, employed full-time in nursing in a hospital, school of nursing, or public health agency, practicing in an acute care situation, and in a relatively high status position. Continuing education non-attenders in 1978 as in 1975 were more likely to be older, less well educated, employed in single-nurse situations such as schools, clinics, or in physicians' offices, practicing in a less acute or more long-term care area, and in a relatively low level position.

The study indicates that the least educationally prepared nurse, functioning in a single nurse situation, and providing the most direct nursing care is least likely to attend continuing education activities. Despite a sophisticated statewide mechanism for provision and coordination

of continuing education in nursing activities, the profile of the typical nurse who did not attend continuing education activities had not changed since 1975. In Indiana, in 1978 as in 1975 the nurse who was possibly the most in need of continuing education in order to remain current in the practice of nursing was least likely to be a participant in continuing education activities.

The results of similar studies done in medicine have led some continuing medical educators to conclude that there is a "hard core" of physicians who would never avail themselves of opportunities to continue their education unless attendance is made mandatory. This study indicates this also may be true for nursing.

The results of this study comparing attendance patterns of registered nurses in Indiana in 1975 and in 1978 provided an empirical basis for the decision to introduce the model piece of MCE legislation into the 1981 Indiana General Assembly.

Much of the opposition to MCE for nurses comes from groups outside of the profession itself and is related to the issues of cost and the "nursing shortage." We have gathered some data related to the costs of CE and the impact of CE requirements on nursing manpower.

In 1975, slightly more CE attenders reported attending entirely on their own time as reported attending entirely on their employers' time.

Attenders were also asked to indicate what percentage of the total cost of their continuing education attendance was paid by them and/or by their employer. One in every four attenders paid all of the cost of their attendance, while one in every three paid none of the cost of their attendance.

The employer tended to pay the registration fee for the continuing education activity more often than did the individual nurse. The individual nurse paid for transportation and meals more often than did the employer. The individual nurse assumed the cost of continuing education materials more than the employer did. The cost of lodging for the continuing education activity was paid by the individual more often than by the employer, but this tendency was slight.

Data related to costs in 1978 was also collected. The results are similar.

Since the cost data was collected in a state where continuing education attendance is voluntary, it seemed essential to determine costs for CE attendance in those states in which attendance is required. Accordingly, I corresponded with the State Nurses' Associations in each of the 11 states in which MCE is in effect. Respondents from most of the states revealed that it was impossible to estimate the cost of CE. Respondents from several states indicated that CE cost was primarily the responsibility of the nurse, while one state suggested that "nurses should have the benefit of attending CE at the employer's expense in proportion to what is allowed for other disciplines. If some money is supplied for other disciplines for CE then the nursing budget should also provide a proportionate amount." One respondent indicated that the average fee for CE attendance varied between \$2 - \$10 per hour; many of the larger employers, such as hospitals, provide CE opportunities for their employees at no cost. Another respondent indicated that a spot check of fees charged by various providers showed that the cost was not unreasonable. In Indiana, the average cost per hour

in 1979 was \$3.33. A respondent from another state indicated that the cost of CE was substantial, both in direct and indirect costs. The direct cost of offerings sponsored by hospitals and community colleges was \$2 - \$3 per hour, while those of commercial sponsors was nearer \$6 per hour. An estimate was offered that each nurse would need to spend \$100 per two years to meet the requirement. In addition, the indirect cost to employers in this state was calculated at nearly \$12 million for release time for nurses.

The data provided relative to the impact of MCE on the nursing shortage was not much more definitive. Several of the respondents indicated they had no data available. A respondent from one state indicated that the Board of Nursing had budgeted an extensive evaluation of the MCE program two years in the future. Another indicated that it would be difficult, if not impossible, and I concur, to isolate the impact of MCE from the many other variables which impinge on the available nursing resources. A respondent from one state in which nurses who seek licensure by endorsement must meet the CE requirements indicated that the result had been a dampening effect on the in-migration of nurses.

Several respondents reported that, while nurses and/or employers were at first disgruntled and unhappy about MCE, once the law was successfully implemented many nurses indicated that they wouldn't have gone to CE if it hadn't been required. Many of those nurses who had not gone to CE activities under a voluntary system acknowledged that participation in CE had been valuable for them. Several of the individuals responding expressed concern about quality control of educational offerings; two of

the states in which the MCE requirement has been in effect the longest indicated that the quality control problem was improving over time.

Two of the respondents indicated a concern that there is no "proof" that CE makes a difference in nursing practice. This is a clear indication of the move toward proof of continued competency for licensed nursing practitioners beyond that minimal competency attested to by passing state boards for licensure.

Continuing education participation is not the only way of ensuring continued competency of nursing practitioners. But in the 11 states which already have mandatory continuing education and in those states similar to Indiana which are moving slowly toward mandatory continuing education, that seems to be the method of choice.

Competency of all health care professionals is essential to ensure the provision of safe health care services to the citizens we serve. This description of the status of continuing education in nursing hopefully will illustrate the concern of the nursing profession. Thank you.

#### Reference

1. Standards for Continuing Education in Nursing. American Nurses' Association, Kansas City, Missouri, August, 1975.